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UNIVERSITY OF CALIFORNIA

The Honorable Willie L. Brown, Jr.
Mayor
City and County of San Francisco
401 Van Ness Avenue
San Francisco, CA 94102

Re: Investigation of Laguna Honda Hospital

Dear Mayor Brown:

On February 7, 1997, we notified you, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq., that we were investigating conditions at the Laguna Honda Hospital and Rehabilitation Center ("LHH") in San Francisco, California. We now are writing to report our findings.

LHH, a public nursing home located in San Francisco, California, is operated by the Department of Public Health of the City and County of San Francisco. There are approximately 1,200 residents at the nursing home who range in age from their young twenties to senior citizens. Approximately eighty percent of the residents are over age 60 and the average age of residents is 72. The population is varied, including residents who are physically or mentally disabled, chronically ill, or acutely ill. Many of the residents have a combination of cognitive impairments or behavior problems and multiple medical problems. LHH's increasingly younger population presents special treatment needs; many of these residents have mental illness combined with medical problems such as drug abuse, alcohol related problems, and Autoimmune Deficiency Syndrome.

The facility is comprised of two residential buildings, the Main Building and Clarendon Hall. The Main Building is the much larger and significantly older of the two structures. The Main Building houses the majority of LHH's almost 1,200 residents. Approximately 160 residents live in Clarendon Hall. Most residents of the Main Building live in large, open wards that house up to 37 residents per ward, with multiple beds in close proximity, separated, at most, by hospital curtains.

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We conducted our investigation by reviewing facility records, including residents' medical charts and other documents relating to the care and treatment of LHH residents; interviewing administrators, staff and residents; and conducting an on-site survey of the facility on June 16-20, 1997 with three expert consultants. At the conclusion of our survey, we briefed LHH administrators and clinicians and City attorneys on our initial findings. We re-toured the facility on November 11-12, 1997 with one of our expert consultants to obtain additional information about health care services at LHH. During the course of our investigation, we were in contact with City attorneys and provided them with information about the status of our investigation. We also invited the City to share information about developments at LHH and the City provided us with updated material. We appreciate the cooperation extended to us during our investigation.

We now have completed our review and, consistent with CRIPA's statutory requirements, we are writing to inform you of our findings. Based on our investigation of resident care and treatment at LHH, we have concluded that there is a pattern of egregious conditions that violate residents' constitutional and federal statutory rights. These violations include inadequate actions to protect residents from harm and provide them with reasonable safety; deficient health care services, particularly in the areas of nursing and specialized rehabilitative services; inadequate activities and stimulation for residents; inappropriate use of restraints; and the failure to provide residents with an adequate and appropriate living environment. In addition, San Francisco fails to serve LHH residents in the most integrated setting appropriate to their needs. A comprehensive survey of LHH during February and March 1998 by the California Department of Public Health (the State's nursing home licensing and certification agency), in consultation with the federal regional office of the Health Care Financing Administration, confirms the continuing existence of serious deficiencies.

We set forth below the facts supporting our findings of unconstitutional and unlawful conditions and practices at LHH and the minimum measures that are necessary to remedy these deficiencies.

I. LHH IS FAILING TO ENSURE THE REASONABLE SAFETY OF ITS RESIDENTS

Individuals who reside in a publicly operated institution, such as LHH, have a fundamental Fourteenth Amendment due process right to live in reasonably safe conditions. Cf. Youngberg v. Romeo, 457 U.S. 307 (1982). Federal statutes governing the operation of nursing homes create similar rights. See, e.g., Grants to States for Medical Assistance Programs (Medicaid),

42 U.S.C. § 1396r; Health Insurance for Aged and Disabled (Medicare), 42 U.S.C. § 1395i-3; and their implementing regulations, 42 C.F.R. §§ 483.10, 483.70, 483.75. LHH violates these constitutional and federal statutory rights of its residents because it does not provide them with adequate protection from harm.

A. Failure to Protect and Supervise Vulnerable Residents

LHH does not take sufficient steps to protect residents who are at risk of harm from their own acts and the acts of others, particularly residents with cognitive impairments and dangerous behaviors. These residents comprise a significant portion of LHH's population; approximately 70 percent of the facility's new admissions have significant dementia, many of whom have accompanying behavioral problems. LHH's failure to provide adequate supervision to these and other residents who are at risk of harm has resulted in serious incidents and injuries.

Resident medical records and occurrence reports describe numerous situations where incompetent or confused LHH residents wandered away from their wards or from the facility without staff being aware that they had left. For example, on March 29, 1997, a resident walked out of the nursing home at 3 a.m. He was found two hours later outside LHH "shivering in the cold" and had suffered multiple abrasions, a nose laceration and a fractured right ankle. In February 1997, another cognitively impaired resident walked away from the facility and was returned "by a passerby" who had found the resident after she had fallen in the street. Other residents, described in LHH records as "disoriented," "confused," or expressing suicidal thoughts, have been found after missing from the facility for hours.

Our review of records also revealed incidents in which residents left the facility and returned under the influence of drugs or alcohol. One resident, who had a documented history of engaging in inappropriate sexual conduct in the facility, was found performing oral sex for money on a male visitor in a hospital elevator. She had liquor on her breath at the time of the incident. Other residents leave their wards and bring alcohol or dangerous objects back into LHH upon their return. One resident who has dementia, delusions and is paranoid and visually impaired, repeatedly wandered out of her ward during a six-week period between February and April 1997. During this period, she gathered several bags of garbage, pudding cans, and nutritional supplements and brought them back to her ward. Staff found tools, other sharp objects, and a 4" by 20" piece of glass wrapped in newspaper in her bedside cabinet. On one occasion, she went into a laboratory and took needles. On another occasion, she took four bottles of Magnesium Citrate from the nursing refrigerator.

We found many other examples where LHH failed to take sufficient steps to protect vulnerable residents and they engaged in dangerous or inappropriate behavior. For example, one resident, whose medical conditions and behaviors placed him at high risk for choking, was found gagging on two pieces of soft bread and cigarette butts and staff had to perform the heimlich maneuver to save him. He was put on strict eating restrictions and staff were told to keep him under "constant supervision" and to lock the ward refrigerator "at all times" so that the resident could not have access to it. However, in March 1997, the resident was allowed unsupervised access to a ward refrigerator. Staff later found him in a bathroom hallway lying on his side with very shallow breathing and a faint pulse. He had choked on a peanut butter sandwich he had eaten from the refrigerator. Although staff attempted the heimlich maneuver, they were unable to revive the resident and he died of asphyxiation caused by aspirating the sandwich.

LHH also fails to provide adequate supervision and treatment to residents with behavior problems and to protect residents who are frequent victims of residents who are combative or aggressive. Despite the increasing number of residents who have behavior problems, only 29 LHH residents as of the time of our June tour had a specific, individualized plan to modify and manage their behaviors. Standard professional practice and federal regulations require such behavior plans as part of the resident's overall plan of care to assist the resident in improving his or her highest level of functioning and to protect other residents. See e.g., 42 C.F.R. § 483.120. Residents with aggressive or combative behaviors have repeatedly victimized other residents and at times have become victims. We reviewed the record of one resident who had organic brain syndrome, hostile behavior, and a history of alcohol abuse. This resident was allowed to wander throughout the facility and frequently verbally and physically abused other residents. The resident also was beaten by an unknown assailant and suffered head lacerations. Another resident with a known history of aggressive behavior, hit a resident on the shoulder and attempted to wheel another resident off of a ward. Several weeks later, she hit a resident with a cane and pool ball. Yet another resident wandered into a LHH ward and was later found by staff trying to choke a resident.

The potential for harm is heightened by LHH's practice of housing frail residents who are confined to their beds with residents who are ambulatory and have aggressive or combative behaviors. In addition, the physical layout of the main building at LHH exacerbates the failure to supervise residents because the wards have relatively easy access to central hallways, the other floors of the building and to the outside.

Another example of the failure of LHH to provide residents with adequate supervision is the facility's practice of allowing cognitively impaired residents to smoke cigarettes in unsupervised or otherwise dangerous settings. For example, the record of one resident documents that staff found her asleep near the oxygen tank in her room with a lighted cigarette in her hand. We reviewed the record of another resident who has dementia; she frequently burned her hands from smoking and was known to be non-compliant with LHH's smoking policies. Still, this resident was allowed to travel throughout the facility, soliciting cigarettes from other residents and picking up cigarette butts out of the cigarette disposal. The fact that LHH houses cognitively impaired residents with alert residents on the same wards compounds the problem of residents keeping smoking materials, such as lighters, in bedside cabinets. Unsafe smoking practices have led to fires and staff have written occurrence reports repeatedly expressing concern about the hazards that residents' unsafe smoking pose. Contributing to the dangers of unsafe smoking practices, we observed that egress corridors were often obstructed with heavy chairs, creating too-narrow routes in case of a fire.

B. <u>Failure to Report and Investigate Serious Incidents and Abuse</u>

Nursing home residents have the right be free from abuse. 42 C.F.R. § 483.13(b). LHH fails to protect residents sufficiently from staff abuse and neglect and victimization by other residents.

The California nursing home licensing and certification agency has cited LHH repeatedly for failing to protect residents from staff abuse and neglect. For years, the State has found incidents where LHH aides fail to respond to call lights or residents' requests for assistance. During the State's February 1997 annual survey, surveyors again found that some residents were positioned in a manner that their call lights were not within their reach and observed another resident repeatedly calling out for help who did not receive assistance. During our June 1997 tour, residents voiced similar complaints about staff's non-responsiveness to their call lights and requests for assistance.

In January 1997, LHH confirmed that an aide punched a 90-year-old resident in the shoulder. One month later, in February 1997, the State Department of Health Services reviewed the facts surrounding an earlier confirmed incident in which another aide also punched an 88-year-old resident in the shoulder. The State agency found that LHH "failed to treat each resident with dignity, respect, and failed to preserve the resident's right not to be subjected to verbal or physical abuse of any kind" and upheld a monetary penalty against the facility.

During the same month, the State conducted its annual survey of LHH and cited the facility for failing to follow its policies on abuse investigations and to report all incidents of alleged staff abuse to the State.

LHH's internal investigation practices are also problematic. The facility does not have an adequate system for investigation of alleged staff abuse and neglect. Nursing supervisors often screen complaints to determine whether they are meritorious before referring them for an investigation. As a result of this selective system, not all serious allegations are investigated. Moreover, residents who are vulnerable and dependent upon staff for their care, have expressed concerns about pursuing abuse allegations due to fear of retaliation.

As noted above, LHH also fails to protect residents from being victimized by other residents. We found incidents where residents had suffered injuries inflicted by another resident or had suffered injuries of unknown origin that were not properly investigated, were not reported to proper authorities, or lacked adequate clinical follow-up. Moreover, in violation of federal regulations and the State's own policies, LHH does not routinely report to State authorities resident injuries of unknown origin, significant wandering events, or resident-to-resident abuse. 42 C.F.R. § 483.13(c)(2).

LHH recently promulgated a new Sentinel Events policy that creates a system to investigate and identify underlying systemic issues for the most serious events, such as suicides and disabling or life-threatening injuries. This system is a positive step but should be expanded to include investigation and individual, as well as systemic, remedial actions for a wider range of incidents and injuries.

In sum, LHH's failure to provide adequate supervision and to use behavior management interventions for the safety of residents who are vulnerable, who have cognitive impairments, or who have behavior problems and its failure to take sufficient measures to prevent abuse and neglect have caused serious harm and violate residents' rights to reasonable safety.

II. LHH IS NOT PROVIDING RESIDENTS WITH ADEQUATE HEALTH CARE SERVICES

Residents of publicly operated institutions, such as LHH, have a Fourteenth Amendment due process right to adequate health care. Cf. Youngberg v. Romeo, 457 U.S. 307 (1982); see also 42 U.S.C. § 1396r(b)(4)(A), 42 U.S.C. § 1395i-3(b)(4)(A) (facility must provide for medical, nursing, and specialized rehabilitative services to "attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident"). Although our medical consultant found

that the level and quality of LHH's medical care appeared to be very good, both he and our other two expert consultants concluded that LHH fails to provide its residents with certain necessary health care services, such as nursing, specialized rehabilitative services, and meaningful activities, to prevent and treat chronic illness and disability.

A. Prevention and Treatment of Illness and Disability

1. Health care assessments and treatment plans are not adequate.

LHH does not provide residents with adequate, individualized health care assessments necessary to develop a comprehensive plan of care to address their acute or chronic health needs and to carry out good preventive practices. Physician assessments appear to be reasonably complete and prompt. But nursing assessments and speech, occupational, and physical therapy assessments do not evaluate all critical aspects of residents' health necessary to develop adequate health care plans. LHH's assessments are particularly deficient in evaluating and monitoring residents' nutritional status, skin care needs, long term effects of the lack of mobility, and psychosocial issues as they relate to the health and well-being of the individual.

Even with a good physician-resident ratio, quality in-house physicians, and an array of medical specialists and clinics, the medical care at LHH is significantly affected by the lack of adequate nursing and specialized therapy assessments of residents' conditions. Without comprehensive ongoing assessments of residents' overall health care needs, it is impossible to develop, implement and monitor appropriate interdisciplinary health care plans for residents. Because staff do not conduct on-going assessments of residents' health care needs, they cannot respond to early warning signs of deteriorations in a resident's health status. Medical and nursing staff tend to respond to crisis situations without providing services necessary to prevent the event from occurring in the first place. Lack of adequate communication among health care providers at LHH also compromises resident care. The various health care disciplines do not work together as an integrated team to identify and address health care concerns.

2. Nursing policies and training do not reflect generally accepted practices.

The Nursing Department at LHH is not performing in a manner consistent with current standards of practice. Nursing staff have not been trained adequately in such key areas as seizure identification or management, medication effects and side effects, physical assessment, mealtime precautions, or appropriate positioning of residents with physical disabilities.

Moreover, at the time of our June on-site visit, LHH's nursing policy and procedure manual was so out of date as to be functionally useless. When our nursing consultant asked for the nursing policy on seizure management, LHH staff admitted the policy was grossly outdated. Out-of-date policies leave nursing staff without clear guidance about current practice in geriatric nursing; yet the vast majority of the policies at LHH had not been revised for more than three years. Of the few policies that have been reviewed and updated, implementation has been inconsistent.

3. Treatment for residents who are at risk of aspiration and precautions during mealtimes are inadequate.

The characteristics of the LHH population place many of them at risk of aspirating food and liquids. However, LHH has failed to identify or treat, on any systematic, interdisciplinary basis, residents with swallowing disorders, residents who need assistance eating, and residents with other medical conditions that place them at risk for aspiration. When we asked the facility to provide a comprehensive list of persons who are at risk for aspiration, the facility did not have such a list. The nursing staff compiled a list during our June tour but did not consult with speech therapy staff who, according to the facility, are responsible for the evaluation and treatment planning for persons at risk of aspiration. When we shared the list with speech therapy staff, they added 25 names to the list -- a clear indication of the lack of the interdisciplinary treatment process.

Our nursing expert identified numerous problems during mealtimes that put residents at further risk of aspiration. For example, there is an insufficient number of staff for residents who need assistance in eating. Frequently, four staff members are responsible for feeding 34 residents. As a result, staff either have to rush residents through meals or delay meals until food is cooled to unsafe temperatures. In addition, we observed staff feeding residents in unsafe positions that place them at risk of aspirating their food. Staff frequently did not follow residents' specialized diet plans, and staff were not adequately trained in feeding residents with oral motor dysfunctions that make swallowing and eating difficult.

These problems are highlighted by the case of one resident who has impaired eating abilities because of dysfunctional oral and mouth control. Nursing staff feed him in a dangerous reclining position that exacerbates his eating problems. As a result, mealtimes are extremely aversive for him and staff have a difficult time feeding him. Nevertheless, LHH nursing and therapy staff have failed to assess this resident to determine the most appropriate position in which to feed him as well as compensatory techniques for placing food in his mouth to

alleviate his chewing and swallowing problems. In May of 1996, the resident's treatment team discussed the insertion of a gastrostomy tube, but this procedure had not been performed as of June 1997. Although this resident had been identified as at risk for aspiration, LHH did not provide individualized therapeutic assessments and interventions to decrease the risk.

Another resident was admitted just prior to our June 1997 tour with a history of aspiration pneumonia and severe dysphagia (difficulty swallowing). Nursing staff did not assess either of these health care problems when the resident was admitted to LHH. Although the resident's chart noted that he occasionally vomits undigested food, there were no interventions or precautions for his symptoms of reflux. Our nursing expert observed another resident shortly after mealtime who was chewing on a diaper provided by the staff. We were told the resident was given the diaper because he would otherwise engage in self-injurious behavior. Although this resident had just returned from a hospitalization for dehydration and aspiration pneumonia, we could find no documentation that the resident had been evaluated for reflux. Reflux can be a cause of aspiration pneumonia, and is a common etiology for hand mouthing or the insertion of other objects into the oral cavity in an attempt to increase the amount of saliva in the esophagus to decrease the amount of acidic burning due to his reflux.

LHH's failure to evaluate and treat adequately such conditions as oral motor dysfunction, reflux, and other conditions that pose aspiration risks, and its failure to follow safe mealtime practices place residents at risk of serious illness.

4. Nurses do not manage seizures and monitor medication side effects adequately.

LHH's nursing staff is inadequately trained in identification of seizures and the anti-convulsant drug management therapies currently in use. The facility revised its seizure management policy during our tour, but even the revised version is inadequate. For example, although nursing interventions are different for different types of seizures, the policy does not make these distinctions. LHH's nursing documentation is also inconsistent regarding resident seizure activity. Without adequate observation and recording of data, it is not possible to develop an adequate seizure treatment plan. Nursing staff also do not monitor the potential side effects of medications adequately, including seizure medications. For example, our nursing consultant reviewed the record of one resident who had a diagnosis of new onset seizures, hypertension, organic brain syndrome, and blindness. Although he was receiving multiple seizure medications with potentially serious side effects, the nursing staff was not monitoring any side effects.

5. LHH fails to communicate adequately with residents about health issues.

Nursing home residents have the right to self-determination and communication with staff about health care decisions. 42 C.F.R. § 483.10. In particular, residents have a right to be fully informed of their "total health status" in a language they understand. 42 C.F.R. § 483.10(b)(3). LHH fails to communicate fully with its multi-ethnic residents and residents whose disabilities pose impediments to adequate communication. Staff stated that they have access to a "language bank" at a local hospital, but these resources and other communication devices, such as communication boards, are underutilized for residents who have language barriers or other obstacles to adequate communication with staff.

One example of this problem is the resident described above, whom staff have great difficulty feeding and whose treatment team has discussed the possibility of substituting oral feedings with a gastrostomy tube. This resident has multiple medical problems that necessitate decisions about the appropriate course of treatment. He is a native Cambodian monk who was admitted to LHH in 1988, does not speak English, and is unable to communicate with ward staff. Facility staff reported that they brought someone in once or twice "years ago" but they were unable to establish any sort of dialogue. This resident is one of many LHH residents who has no advocate, no one to speak for him, or even to speak to him -- even as life-or-death decisions are being made about him. A related problem is that many impaired LHH residents do not have a guardian or responsible party to make health care decisions for them, leaving these decisions to be made by LHH's treatment teams.

The importance of staff being able to communicate with residents is underscored by the case of a resident who committed suicide at LHH in March 1997. The resident, who spoke only Chinese, had repeatedly told his family that he wished to return to China and would commit suicide if he were not returned there. LHH documents state that this information was never passed from the family to facility staff and communication between the resident and staff was likely impaired because of the limited number of LHH staff who could communicate with the resident.

B. Emergency Response

We also found some deficiencies in LHH's ability to respond to medical emergencies. LHH's internal reviews of "Code Blue" emergencies document that essential equipment and medications, such as oxygen and epinephrine, are not always immediately available at LHH for staff to respond appropriately to emergencies. In addition, there has been confusion on some codes about the roles of the various members of the emergency response

team and outside paramedics and about when to call 911. Our nursing consultant witnessed a "Code Blue" during her June tour of LHH and had several concerns based on her observations, including nursing staff failing to use appropriate resuscitation techniques and difficulties in establishing an intravenous line. Staff appeared inadequately trained and unfamiliar with intravenous procedures. For example, the intravenous pole was too short so the resident's blood backed up into the tubing. Moreover, the nursing evaluation of this incident did not identify these issues.

C. Specialized Rehabilitative Therapy and Activity Services

Under federal regulations, a nursing home "must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life." 42 C.F.R. § 483.15. This means that nursing home residents have the right to receive care and services necessary to "attain or maintain the highest practicable physical, mental, and psychosocial well-being." 42 C.F.R. § 483.25. These services include "specialized rehabilitative services," such as physical, occupational and speech therapy, as well as recreational and stimulating activities. 42 C.F.R. §§ 483.15, 483.45

At the time of our June survey, LHH reported that 672 of its 1,200 residents had either an altered diet or were tube fed and 758 residents spent the majority of their time in bed or in a chair. However, only approximately 50 residents were receiving physical, occupational or speech therapy services. Speech therapy staff had assessed, at most, only one-third of the residents identified by LHH as at risk for aspiration and they had assessed only 10 percent of the more than 700 residents who required assistance with eating. Given the number of residents who have difficulty eating, the lack of oral motor assessments and interventions is a significant deficiency that poses great health risks. Similarly, the lack of adequate physical therapy services in a nursing home setting typically results in more residents losing functional abilities, resulting in residents being confined to their wheelchairs or beds due to a deterioration of their physical abilities and overall health.

A major reason for the failure to provide adequate speech, occupational and physical therapy services appears to be the lack of staffing. Due to inadequate numbers of staff, the therapy staff serve more in a consultant role than as actual members of the interdisciplinary team. Therapy staff rely exclusively on referrals from the in-house staff or family members. According to discussions with therapy staff, they develop a therapy program for a resident, provide some staff training, and then rely on the nursing staff to implement the program. This process does not provide adequate follow-up of therapy programs by the therapy staff.

There also is a lack of sufficient resident activities at LHH, in violation of the federal statutory rights of nursing home residents. See, e.g., 42 C.F.R. § 483.15(f)(a)("facility must provide for an ongoing program of activities designed to meet ... the interests and the physical, mental, and psychosocial well-being of each resident"). The facility fails to engage its residents in adequate, appropriate and meaningful activities and to schedule a variety of activities to accommodate the diverse needs of the population. A number of residents spend the vast majority of their day in their beds or in chairs next to their beds. LHH's Director of Activities agrees that there are insufficient activity staff to provide adequate stimulation and activities for LHH residents, particularly given the number of residents who require considerable individual time and attention.

In sum, LHH is not meeting the specialized rehabilitative therapy and activity needs of its residents. As a result, the facility is not helping residents attain their highest practicable physical, mental, and psychosocial well-being as required by 42 C.F.R. § 483.25, and residents suffer an increased risk of morbidity, mortality and deterioration.

III. LHH'S RESTRAINT PRACTICES ARE PROFESSIONALLY UNJUSTIFIABLE AND DANGEROUS TO RESIDENTS

Nursing home residents have constitutional and federal statutory rights to be free from physical or chemical restraints imposed for the convenience of staff and without medical justification. Youngberg v. Romeo, 457 U.S. 307 (1982); 42 U.S.C. § 1396r(c)(1)(A)(ii). LHH uses restraints on its residents in violation of accepted standards of practice and in ways that threaten the health and safety of residents.

As noted earlier, despite the prevalence of residents with behavior problems, only a small number of residents have behavior management plans. State licensing surveyors have repeatedly cited LHH for its reliance on psychotropic medications and physical restraints in lieu of less intrusive behavior management plans. In addition, LHH uses bedrail restraints while residents are in bed on almost 50 percent of its residents. Because professional standards of practice have eliminated the need for physical restraints except under limited medical circumstances, federal regulations require facilities to demonstrate a specific medical symptom that requires the use of restraints, and how the use of restraints treat the cause of the symptom and assist the resident in reaching his or her highest level of physical and psychosocial well-being. The justifications for use of restraints in LHH medical records do not satisfy this standard.

Moreover, the facility's use of bedrails exposes residents to the risk of injuries, such as skin tears, and the risk of arms or legs becoming entangled in the bedrails. As we noted at the

time of our June tour, LHH's practice of simultaneously using bedrails and vest restraints to confine residents to their beds is an unsafe procedure that is contrary to accepted professional standards. Finally, LHH does not attempt to use less restrictive and safer restraints, such as rolled bumper cushions, bed alarms or an adjacent-to-bed floor mattress in violation of standards of practice set by federal regulations. 42 C.F.R. § 483.13(a).

IV. LHH IS NOT PROVIDING RESIDENTS WITH AN ADEQUATE AND APPROPRIATE LIVING ENVIRONMENT

Nursing home residents have federal rights under the Medicaid/Medicare regulations to live in an adequate and appropriate environment. See e.g., 42 C.F.R. § 483.15(h)(1) (the nursing home must provide a safe, "comfortable, and homelike environment"); 42 C.F.R. § 483.10(e) (nursing home residents have a "right to personal privacy"); 42 C.F.R. § 483.15 ("[a] facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life"); 42 C.F.R. § 483.15(a) ("the facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect"); and 42 C.F.R. § 483.10 (residents have a "right to a dignified existence"). LHH fails to provide residents these rights. As noted above, most LHH residents live on large, open, often co-ed wards with up to 36 other residents. The level of noise and constant traffic throughout the wards makes privacy almost impossible, and it is difficult for ill residents to get needed rest. Residents' beds are frequently only a few feet apart from one other and the only partitions separating the beds are hospital curtains. However, we noted that at least two wards did not even have these curtains. Residents in a number of wards do not have easy access to bathrooms. These conditions create both privacy and infection control problems, since residents who soil themselves in their beds must travel through the open ward to an area where they can be cleaned. Moreover, although over half of LHH residents are incontinent, only approximately 25 residents are on bowel or bladder training programs to give them greater comfort and control over their bodily functions and decrease the risk of skin breakdown from constant irritation.

V. FAILURE TO PROVIDE SERVICES IN THE MOST INTEGRATED SETTING

The Justice Department has promulgated regulations pursuant to Title II of the Americans with Disabilities Act ("ADA") that require public entities to provide services to qualified individuals with disabilities in the most integrated setting appropriate to their needs. 28 C.F.R. § 35.130(d). San Francisco is failing to ensure that LHH residents are being served in the most integrated setting pursuant to the ADA.

Although Medicaid/Medicare regulations require an evaluation every three months to determine the discharge potential of each nursing home resident (42 C.F.R.§ 483.20(5)), LHH professionals are not conducting meaningful assessments of most residents to determine whether the nursing home is the most integrated setting to meet their needs. However, there are some residents whom LHH professionals have assessed and determined should be served in a more integrated setting. Many of these residents have spinal cord injuries and use wheelchairs. They could live in the community independently or with some supportive services. But these and other residents remain at LHH because there are barriers to an alternative placement, primarily a lack of sufficient accessible housing or support services, such as attendant care, supportive adult day programs, or out-patient health services. Various city and county agencies in San Francisco provide housing and supportive community services to disabled and elderly individuals. San Francisco's failure to provide qualified LHH residents with these services constitutes unnecessary segregation and is a violation of Title II of the ADA. See, e.g., L.C. v. Olmstead, 1998 WL 163707 (11th Cir. Apr. 8, 1998); Helen L. v. DiDario, 46 F.3d 325 (3d Cir.), cert. denied sub nom, Pennsylvania Secretary of Public Welfare v. Idell S., 516 U.S. 813 (1995). In addition, Title II of the ADA requires that the City's housing programs, when viewed in their entirety, are accessible to persons with disabilities.

We are aware that San Francisco is examining ways in which to enhance options for people to remain in their homes and communities. In fact, LHH's chief executive officer recently left his position at LHH to co-chair San Francisco's Long Term Care Task Force. The mission of this Task Force is to provide a continuum of health and social services that fosters independence for elderly and disabled individuals in the least restrictive environment. We are willing to work with the City to explore possible sources of federal funding and technical assistance to increase community residential services for LHH residents, including assistance from the United States Department of Housing and Urban Development to provide housing through such mechanisms as rental options in publicly subsidized buildings, home ownership options, and use of certificates and vouchers.

VI. MINIMUM REMEDIAL MEASURES

In order to remedy these deficiencies and to protect the constitutional and federal statutory rights of LHH residents, LHH should implement promptly, at a minimum, the following measures:

1. Provide a safe environment for LHH residents. LHH should identify and take adequate steps to protect all residents who are at risk of harm from their own acts and the acts of others, including residents with cognitive impairments and behavior problems. These steps should include adequate staff

supervision and behavior management programs. LHH should also identify residents who are subject to being victimized and take adequate steps to protect them. To the extent possible, LHH should separate cognitively impaired and confused residents from higher-functioning, potentially aggressive residents. In addition, LHH staff should ensure that residents follow safe smoking practices and that egress corridors are not obstructed.

2. Protect residents from abuse and neglect. LHH should establish and maintain an adequate facility-wide system for reporting and investigating residents' injuries, abuse, and neglect. LHH should develop and implement policies and procedures to conduct an independent and thorough investigation of all allegations of staff abuse and neglect, ensure that appropriate disciplinary steps are taken, and address any underlying systemic issues leading to abuse. The abuse investigators should be independent of the facility. Finally, LHH must follow State and federal regulations on reporting injuries and incidents to State authorities.

3. Provide residents with adequate preventive, chronic, and emergency health care in accordance with generally accepted professional standards. In order to accomplish this, LHH should:

a. ensure all residents receive timely, individualized, comprehensive assessments that are adequate to determine their health care needs;

b. conduct adequate assessments of the specialized rehabilitative therapy needs of residents (including speech, occupational, and physical therapy services) and ensure that needed services are provided in a timely manner by qualified staff;

c. develop and implement adequate interdisciplinary care plans to address each resident's complete health care needs;

d. monitor and review residents' health status and respond to changes in a resident's health status in a timely manner;

e. revise nursing procedures to ensure they reflect current standards of practice;

f. identify and provide appropriate treatment for residents who are at risk of aspiration;

g. provide adequate nutritional management services, including adequate nutritional assessments of individual residents' specific nutritional needs;

h. ensure that residents who need assistance in eating are assisted by adequately trained staff who feed the residents in a safe and appropriate manner;

i. provide appropriate seizure management;

j. ensure that nurses monitor medication side effects; and

k. ensure that there is adequate, functioning equipment to respond to emergencies, that staff are adequately trained in emergency response and understand their roles, and that LHH adequately reviews its responses to emergencies and takes corrective action when needed.

4. Ensure adequate communication with residents. Where there are language barriers or other impediments to adequate communication with staff, LHH should use translators and other devices, such as communication boards, to facilitate communication.

5. Provide sufficient, meaningful, stimulating activities to residents and make all due efforts to get residents involved in activities.

6. Ensure that all LHH staff, including physicians, nurses, therapists and direct care, are adequately trained in current standards of practice in all relevant areas of health care delivery. Provide, to all health care staff, competency-based training that requires staff to demonstrate both their knowledge and ability to perform tasks in the following areas: mealtime precautions and safe feeding practices; seizure identification and management; positioning; and skin care. In addition, LHH should provide competency-based training to nurses in the following areas: physical assessment; treatment planning (interdisciplinary); and medication effects and side effects.

7. Provide a sufficient number of nurses and aides to provide adequate assessment, treatment, and supervision of LHH residents.

8. Provide a sufficient number of specialized rehabilitation therapists, including physical therapists, occupational therapists, speech therapists, and activity specialists to provide adequate treatment and stimulating activities to each LHH resident.

9. Cease using vest restraints with bedrails. LHH should also ensure that the safest and least restrictive means of bodily restraints are used, pursuant to accepted professional standards and federal law, and such restraints are only used when there is a documented medical symptom that requires the use of restraints, and are never used for the convenience of staff or as punishment.

Staff must follow physicians' orders, use restraints appropriately, and monitor the status of residents who are being restrained.

10. Provide residents with an adequate and appropriate living environment that affords them privacy.

11. Ensure that appropriate individuals under California State law are appointed to act on a resident's behalf when a resident has been adjudged incompetent or wishes to delegate a surrogate decision-maker in accordance with 42 C.F.R. § 483.10(a)(3) and (4).

12. Conduct regular professional assessments to identify residents who could be served in more integrated settings and provide adequate housing or supportive services to assist these individuals in moving from LHH to the community.

13. Develop an effective monitoring and quality assurance mechanism to ensure compliance with the remedial measures.

Pursuant to CRIPA, the Attorney General may initiate a lawsuit to correct deficiencies at an institution 49 days after appropriate local officials are notified of them. 42 U.S.C. § 1997b(a)(1). However, in light of the cooperation the City has provided us, we look forward to discussing with you and other City officials how we might resolve the existing systemic deficiencies in a non-adversarial manner. We hope to be able to work with you and other City officials to resolve this matter in a reasonable and expeditious manner.

Sincerely,

Bill Lann Lee
Acting Assistant Attorney General
Civil Rights Division

cc: Louise H. Renne, Esq.
City Attorney
City and County of San Francisco

Mitchell Katz, M.D.
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City and County of San Francisco

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Director of Health

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DEPARTMENT OF PUBLIC HEALTH INITIAL RESPONSE TO REPORT FROM THE DEPARTMENT OF JUSTICE

Since it was founded in 1866 -- on its present site -- by the City and County of San Francisco, Laguna Honda Hospital (LHH) has served as a facility of enduring care. Although its precise mission has changed over these 130 years, its goal has always remained consistent: to provide compassionate and excellent medical care to the more vulnerable residents of San Francisco. We believe that we have fulfilled that mission with excellence.

Today, LHH provides long term skilled nursing care to approximately 1200 residents. These residents are diverse, with people from many different age and ethnic groups and cultures, presenting many different medical diagnoses and behavioral challenges. Some LHH residents are mentally alert and articulate; others suffer from

Alzheimer's disease or other forms of dementia. Many of our residents are medically complex, with multiple diagnoses.

Despite this diversity and range of medical challenges, LHH addresses the residents' needs with excellence. We provide our residents with individualized treatment for their particular illness or disability. LHH offers each resident a team of professionals, including: physicians; nurses; psychologists; social workers; dietitians; pharmacists; and physical; occupational; speech; and activity therapists. Unlike most long term care facilities, which rely on outside consultants to meet residents' medical needs; we maintain a staff of in-house physicians. In addition, our staff turnover rate for nurses and nursing assistants is among the lowest in the field. This staff stability, and the staffs' familiarity with individual residents -- as people, not just patients -- helps LHH to provide its residents with excellent medical and nursing care. Our other staff members, such as food preparers, laundry workers, and porters, help us to maintain LHH 24 hours a day, seven days a week, to make LHH a comfortable and secure home for its residents.

Our residents live in 39 skilled nursing care units. We view these units as separate distinctive neighborhoods, each with its own special character, within the larger LHH community. This sense of neighborhood and community helps to reduce the isolation of illness faced by many of our residents. LHH also maintains separate specialized units -- homes within our facility -- for people who require intensive rehabilitation, for those suffering from AIDS, for residents with dementia who require a safe and secure environment, and for those, who nearing the end of their life, desire hospice care.

As health care administrators, we are accustomed to surveys and investigations of long-term health care facilities, which are regulated by a complex set of federal and state regulations. As a result, we are also accustomed to critiques from a variety of sources. We believe that our primary duty is to provide high-quality medical care for our residents, and we perform that serve with excellence.

Last year, the U.S. Department of Justice initiated an investigation of Laguna Honda Hospital, pursuant to the Civil Rights of Institutionalized Persons Act. Laguna Honda Hospital was selected from among many different publicly owned institutions, such as mental health hospitals, jails, prisons, and nursing homes that the Justice Department investigates throughout the country every year.

The Department of Justice conducted site visits of Laguna Honda Hospital in June and November 1997. Today, May 6, 1998, the U.S. Department of Justice, in Washington, DC, sent an 18-page letter concerning Laguna Honda Hospital to Mayor Brown. The letter recognizes the cooperation exhibited by the City, and that the Department of Justice looks forward to working with the City in a non-adversarial manner. We, too, wish to continue working with the Justice Department as cooperatively as possible to further improve the services that we provide to Laguna Honda Hospital residents.

Because we received this letter only this morning, we have had not had the opportunity to review it in detail. Our initial response to the letter may be summarized as

follows: First, in some circumstances, we believe that the Department of Justice has identified some areas in need of further improvement. Primarily, these areas concern the quality of life and level of activities that we provide to our residents. We believe that our primary duty is to provide high quality medical care for our residents, and even the Department of Justice acknowledges that our medical services are very good. We must now focus on the ways that we enhance the safety, comfort, and activity levels of our residents.

Second, in other instances, we believe that the Department has not accurately or fairly described or assessed the services at Laguna Honda Hospital. Sometimes, the letter highlights what are isolated instances of fact, and draws expansive conclusions from them.

As in the past, LHH will provide its residents with excellent care despite difficult and challenging circumstances. LHH is not a typical nursing home. We are not a private sector business. We cannot carefully select only those residents that present the least amount of risk. We do not turn away individuals merely because of their medical complexities. We find ourselves caring for a resident population with increasingly complex medical and psychiatric needs, and residents under 55 years of age who may be more physically and mentally alert than some of our older residents. Accommodating the diverse needs of these groups requires us to develop new programs. This is a considerable challenge, but one upon which we have already embarked.

8/8/99 1-99
Valerie Nelson

However, we will continue to work cooperatively with the Department of Justice, and will not allow their letter to deter us from further improving our services. Instead, we will use the Department of Justice critique as an opportunity to reassess and further enhance the quality of life and safety for our residents.

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